Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098 3926

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-2016-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Table of Disputed Services: "IC failed to pay per DWC Rule 134.404 Hospital Facility Fee Guideline. Per DWC Rule 134.404, claim pays @ Medicare allowable of DRG 460 $30,395.83 x 108% = $32,827.50; Implants (revenue code 278) reimbursed @ cost ($49,018.00) x 110% = $53,919.80; total allowable: $86,747.30"

Amount in Dispute: $46,928.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual believes the amount paid for the implants is correct and will submit additional supporting information for this."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2011 To September 3, 2011	Inpatient Hospital Surgical Services	$46,928.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the

requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 27, 2011
   - CAC-16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - CAC-206 — NATIONAL PROVIDER IDENTIFIER – MISSING.
   - F03 — A MEDICARE NUMBER IS REQUIRED TO CALCULATE THE CMS INPATIENT REIMBURSEMENT.
   - 895 — 133.210 REQUIRES ITEMIZED STATEMENT FOR HOSPITAL SERVICES.

   Explanation of benefits dated December 5, 2011
   - CAC-W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-97 — THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 — THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 420 — SUPPLEMENTAL PAYMENT.
   - 468 — REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
   - 891 — NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 897 — SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134; SUBCHAPTER (E) HEALTH FACILITY FEES

   Explanation of benefits dated January 4, 2012
   - CAC-W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-97 — THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
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- 897 — SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134; SUBCHAPTER (E) HEALTH FACILITY FEES

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).

Description of Implant per Itemized Statement	Quantity	Amt Billed	Invoice Cost	Cost + 10%
Bone Graft, Infuse Large	1	$37,430.00	$5,408.00	$5,408.00 + $540.80 = $5,948.80
Peek XL Spacer 10 MM	1	$14,670.00	$2,125.00	$2,125.00 + $212.50 $2,337.50
SAS S4 Rod 5.5 x 60 SW 65	2	$1,258.00	$110.00/each	$110.00 + $11.00 $121.00 X 2 = $242.00
AS Screw 10x 45 S4 SW81	2	$9,608.00	No Invoice Submitted	$0.00
S4 Set Screw SW790T	6	$2,082.00	$82.00/each	$82.00 + $8.20 $90.20 X 6 = $541.20
Ped Screw 8 x 45 SW746T	2	$5,192.00	$495.00/each	$495.00 + $49.50 $544.50 X 2 = $1,089.00
Ped Screw 8 x 50 SW747T	2	$5,192.00	$495.00/each	$495.00 + $49.50 $544.50 X 2 = $1,089.00
TOTAL DUE				$11,247.50

3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 460 is $21,485.46. This amount multiplied by 108% is $23,204.30.The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $10,225.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,022.50. The total maximum allowable reimbursement (MAR) is therefore $34,451.80. The respondent previously paid $39,819.21, therefore no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		March 19, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.